

## § 412.604

*Comorbidity* means a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

*Discharge.* A Medicare patient in an inpatient rehabilitation facility is considered discharged when—

(1) The patient is formally released from the inpatient rehabilitation facility; or

(2) The patient dies in the inpatient rehabilitation facility.

*Encode* means entering data items into the fields of the computerized patient assessment software program.

*Functional-related groups* refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

*Interrupted stay* means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the third day.

*Outlier payment* means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

*Patient assessment instrument* refers to a document that contains clinical, demographic, and other information on a patient.

*Rural area* means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in § 412.62(f)(1)(iii). For discharges occurring on or after October 1, 2005, rural area means an area as defined in § 412.64(b)(1)(ii)(C).

*Transfer* means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in § 412.23(e), or a nursing home

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that qualifies to receive Medicare or Medicaid payments.

*Urban area* means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in § 412.62(f)(1)(ii). For discharges occurring on or after October 1, 2005, urban area means an area as defined in §§ 412.64(b)(1)(ii)(A) and 412.64(b)(1)(ii)(B).

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003; 70 FR 47952, Aug. 15, 2005]

### § 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after January 1, 2002, an inpatient rehabilitation facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare Part A fee-for-service beneficiaries, CMS or its Medicare fiscal intermediary may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in § 412.1(a)(1).

(b) *Inpatient rehabilitation facilities subject to the prospective payment system.* Subject to the special payment provisions of § 412.22(c), an inpatient rehabilitation facility must meet the general criteria set forth in § 412.22 and the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§ 412.23(b), 412.25, and 412.29 for exclusion from the inpatient hospital

prospective payment systems specified in §412.1(a)(1).

(c) *Completion of patient assessment instrument.* For each Medicare Part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with §412.606. IRFs must also complete a patient assessment instrument in accordance with §412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009.

(d) *Limitation on charges to beneficiaries*—(1) *Prohibited charges.* Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§409.82, 409.83, and 409.87 of this subchapter and for items or services as specified under §489.20(a) of this chapter.

(e) *Furnishing of inpatient hospital services directly or under arrangement.* (1) Subject to the provisions of §412.622(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in §409.10 of this subchapter. Inpatient hospital services do not include the following:

(i) Physicians' services that meet the requirements of §415.102(a) of this subchapter for payment on a fee schedule basis.

(ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(v) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(vi) Services of an anesthetist, as defined in §410.69 of this chapter.

(2) Medicare does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient of the inpatient rehabilitation facility, except for services described in paragraphs (e)(1)(i) through (e)(1)(vi) of this section.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in §409.3 of this subchapter).

(f) The prospective payment system includes payment for inpatient operating costs of preadmission services that are—

(1) Otherwise payable under Medicare Part B;

(2) Furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the inpatient rehabilitation facility, or to an entity wholly owned or wholly operated by the inpatient rehabilitation facility; and

(i) An entity is wholly owned by the inpatient rehabilitation facility if the inpatient rehabilitation facility is the sole owner of the entity.

(ii) An entity is wholly operated by an inpatient rehabilitation facility if the inpatient rehabilitation facility has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the inpatient rehabilitation facility also has policymaking authority over the entity.

(3) Related to the inpatient stay. A preadmission service is related if—

(i) It is diagnostic (including clinical diagnostic laboratory tests); or

(ii) It is nondiagnostic when furnished on the date of the beneficiary's inpatient admission; or

(iii) On or after June 25, 2010, it is nondiagnostic when furnished on the calendar day preceding the date of the

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beneficiary's inpatient admission and the hospital does not attest that such service is unrelated to the beneficiary's inpatient admission.

(4) Not one of the following—

(i) Ambulance services.

(ii) Maintenance renal dialysis services.

(g) *Reporting and recordkeeping requirements.* All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003; 74 FR 39810, Aug. 7, 2009; 75 FR 50417, Aug. 16, 2010]

## § 412.606 Patient assessments.

(a) *Admission orders.* At the time that each Medicare Part A fee-for-service patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) *Patient assessment instrument.* An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatients who—

(1) Are admitted on or after January 1, 2002; or

(2) Were admitted before January 1, 2002, and are still inpatients as of January 1, 2002.

(c) *Comprehensive assessments.* (1) A clinician of the inpatient rehabilitation facility must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare Part A fee-for-service inpatient using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of this section as part of his or her patient assessment in accordance with the schedule described in § 412.610. IRFs must also complete a patient assessment instrument in accordance with § 412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009.

(2) A clinician employed or contracted by an inpatient rehabilitation

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facility who is trained on how to perform a patient assessment using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of the section must record appropriate and applicable data accurately and completely for each item on the patient assessment instrument.

(3) The assessment process must include—

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family, someone personally knowledgeable about the patient's clinical condition or capabilities, the patient's clinical record, and other sources.

[66 FR 41388, Aug. 7, 2001, as amended at 74 FR 39810, Aug. 7, 2009]

## § 412.608 Patients' rights regarding the collection of patient assessment data.

(a) Before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient—

(1) The form entitled “Privacy Act Statement—Health Care Records”; and

(2) The simplified plain language description of the Privacy Act Statement—Health Care Records which is a form entitled “Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities.”

(b) The inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in paragraph (a) of this section.

(c) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility will inform the Medicare patient of—

(1) Their privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

(i) The right to be informed of the purpose of the collection of the patient assessment data;